SAIIE

"Your Life Experience; Your Education"

Medical Consent to treat a Minor

I, _____,

parent or legal guardian of _____

, born the ____ day of _____, _____

hereby authorize the diagnosis and treatment by a qualified and licensed medical professional, of the minor child, in the event of a medical emergency, which in the opinion of the attending medical professional, requires immediate attention to prevent further endangerment of the minor's life, physical disfigurement, physical impairment, or other undue pain, suffering or discomfort, if delayed.

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for the named student. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that every attempt will be made by the attending physician to contact me in the most expeditious way possible. This authorization is granted only after a reasonable effort has been made to reach me.

Permission is also granted to the SAIIE staff. and its affiliates including Directors, Coaches, and Team Parents to provide the needed emergency treatment prior to the child's admission to the medical facility.

Release authorized on the dates and/or duration of the program.

This release is authorized and executed of my own free will, with the sole purpose of authorizing medical treatment under emergency circumstances, for the protection of life and limb of the named minor child, in my absence.

This authorization is effective throughout the duration of the program, from ___ /___ /_____ to ___ /___ /_____

***If the student is a minor this form must be signed by a parent or legal guardian.**

_____ ____/_____/_____

Signature of Participant Student Date

_____ ____/_____/_____

Signature of Parent or Legal Guardian Date

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Student´s Name: _____

Last Name: _____

Please write the student's name and last name in capital letters.
Please make sure to fill out the form as clear as possible.

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address _____

Father's Telephone: _____ Mother's Telephone: _____

Last Tetanus: _____

Allergies to drugs or foods:

_____

Special Medications, Blood Type or Pertinent Information:

_____

_____

_____

_____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy # _____

Preferred Hospital: _____